DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **04-02**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **January 1, 2004**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 460.182	7. FEDERAL BUDGET IMPACT: **a. FFY 01/01/04 – 09/30/04 $0** **b. FFY 10/01/04 – 09/30/05 $0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B, Pages 17(a) through 17(d)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B, Pages 17(a) through 17(d)**

10. SUBJECT OF AMENDMENT:
Non-Institutional, Program of All-Inclusive Care for the Elderly (PACE)

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Governor's Office has reviewed and approved

12. SIGNATURE OF STATE AGENCY OFFICIAL: Kathryn Kuhmerker	16. RETURN TO: **New York State Department of Health, Corning Tower, Empire State Plaza, Room 1466, Albany, New York 12237**
13. TYPED NAME: **Kathryn Kuhmerker**	
14. TITLE: **Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: March 2, 2004	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: MAR 13 2004
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2004	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Sue Kelly	22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

OFFICIAL

State of New York

Attachment 4.19-B
Page 17(a)

~~Upper Payment Limit and Rate Methodology~~

~~The methodology used by New York State to determine a Medicaid capitation PMPM rate for a PACE provider follows a two-step process. First, the Department determines a fee-for-service equivalent per member per month cost for State Plan approved services provided to an equivalent non-enrolled population group. This is called the Upper Payment Limit (UPL). Then, this cost level, and/or any information received from the PACE provider, such as the provider's anticipated enrollment, projected utilization of services and costs, and/or any other relevant information, are used by the Department of Health to determine a per member per month capitation rate. This rate does not exceed the fee-for-service equivalent per member per month cost (i.e., the UPL in step one) developed by the Department.~~

~~In the following two sections, these two steps in the rate determination process are described in more detail.~~

~~Step 1: Development of the Upper Payment Limit (UPL)~~

~~The purpose of the Upper Payment Limit is for the State to ensure that the Medicaid monthly capitation payment amount for a PACE provider is less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program.~~

~~The base period data file used by the Department for the purpose of developing the UPL's was an individual-specific file on recipients, 55 years of age or older, of long-term care services in New York State's fee-for-service program. These long-term care services included community-based services as well as nursing home care. Only the costs of State Plan approved services from this data file were used for the development of the UPL's. The data file contained expenditures by category of service and eligibility category. Since the file was of recipients of long-term care services under the State's Medicaid program, individuals qualifying under the QMB Only, QDWI, SLMB, QI1, and QI2 programs were by definition excluded from this data base. Furthermore, recipients enrolled in capitated Medicaid managed care programs, including PACE participants, and their services were excluded.~~

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~~In order to prepare the base period fee-for-service data file for further analysis, a number of adjustments were made. Claims completion factors were developed based on an examination of the data to determine the claims payment lag by service category. These completion factors were then applied to adjust the base period file expenditures. The pharmacy expenditures in the file were adjusted to net out the impact of rebates for pharmaceutical drugs. For transportation expenditures, an adjustment was made for payments not processed through the MMIS. In order to develop the UPL's for premium groups pertaining to Medicaid Only Eligible individuals, adjustments were also made to the hospital inpatient expenditures in the base period file to exclude graduate medical education (GME) payments, since PACE providers do not make a GME payment to their contracted hospitals.~~

~~Once the base period expenditure data were assembled and adjusted as described above, the data base was separated into the Medicare-Medicaid Dual Eligible individuals and Medicaid Only Eligible individuals to proceed with UPL development. As a first step, analyses were undertaken to assess the need to smooth the data to improve the variability of rates and improve average predictability. For example, since it was intended that provider capitation rates and hence the UPL's were to be on a county-specific level, an analysis was performed to determine whether significant cost variations existed across counties within a given region. A finding of such variation would suggest a smoothing adjustment. However, the analysis of the dual eligible population did not find that variations in costs within regions were significant and hence no smoothing adjustment was applied to the expenditure data for this purpose. No stop loss provisions are included in the PACE capitation rates and hence no such feature was reflected in the UPL development.~~

~~The analyses of the data base on the fee-for-service expenditures of individuals eligible for Medicaid Only found that the numbers of long-term care recipients by county were extremely small for several counties. Hence, in lieu of UPL's developed on a county-specific basis for the Medicaid Only Eligible population, region-specific UPL's were developed. The regions used were New York City, Downstate Suburban, Upstate Urban, and Upstate non-Urban counties.~~

~~The data were also examined to determine the appropriate rate category groupings. In lieu of age-based or gender-based rate groupings, the State chose to differentiate Upper Payment Limits by a "High" and a "Low" risk group based on an analysis of cost variation among fee-for-service enrollees. The "High" group was defined as representing individuals with a DMS-1 score of 180;the "Low" group represented individuals with a score of 60 to 179. The DMS-1 is the state-designated tool for determining nursing facility level of care. The UPL for each county, and the UPL for each region for the Medicaid Only Eligible population, were separated into a "High" and "Low" category using these thresholds.~~

~~Using the base year fee-for-service expenditures as described above, updates of the UPL's for a given rate year were achieved through inflation factors based on State fee-for-service increases in rates for various categories of expenditures pertaining to the long term care population. This update also included a review for program changes in fee-for-service long-term care for inclusion into the UPL's.~~

~~The methodology, as described above, produced Upper Payment Limits for the PACE eligible population, i.e., individuals who are Medicare-Medicaid dual eligible and are 55 years of age or older and certified for nursing home care, on a county-specific basis in rate period dollars. Separate UPL's were determined for the "High" and "Low" groups. Regional UPL's, separated into the "High" and "Low" categories were also produced for the PACE eligible population who have only Medicaid coverage and are 55 years of age or older.~~

~~Step 2: Provider Rate Proposal Submission and Rate Determination~~

~~This step constitutes the second step in the process of rate determination, with the UPL development (as described above) being the first. Each PACE provider submits a rate proposal to the State. The State provides the format, guidelines, and instructions for the rate proposal document. In the rate proposal, the provider is instructed to indicate anticipated enrollment, identify the types of services that will be provided to its enrollees, projected levels of utilization of services and the assumptions underlying these projections, and projected prices the provider will have to pay for these services. The rate proposal by a provider shows the monthly capitation rate being requested separately for the "High" and "Low" groups.~~

~~The rate proposal submitted by the provider is reviewed by the State. This review evaluates the reasonableness of utilization projections, appropriateness of unit prices of services, provider arrangements, expected administrative expenditures, historical cost experience and other factors. The result of this review is a capitation rate, separately for the "High" and "Low" groups, determined by the State, after discussions with the plan. This capitation rate excludes the enrollee share amount based on the enrollee's applicable spenddown liability and Net Available Monthly Income (NAMI). The State ensures that the capitation rate approved for the provider does not exceed the appropriate upper payment limit (UPL) as developed in step one described above. The rate determined by the Department is subject to the approval of the State Division of the Budget.~~